What structural support system protects the sexual and reproductive health rights of young people in Ebonyi State, Nigeria?

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Abstract

Background: Negative attitudes of health workers pose a barrier to young people's access to Sexual and Reproductive Health Services(SRHS). While many studies have reported on such barriers, studies on structures that protect SRH service rights of young people are scarce. This current study uses a qualitative research approach to identify and understand the roles of existing structures that protect the SRH rights of young people in Ebonyi State Nigeria.

Methods: This study was cross-sectional qualitative research. Participants included young people and healthcare providers drawn from six local government areas (LGAs), evenly representing rural and urban regions in Ebonyi State. Elicited data from the In-depth Interviews and Focus Group Discussions were analyzed thematically.

Findings: Our findings showed young people report unprofessional attitudes of healthcare providers to different existing organizational and community structures that protect their SRH rights. Three different organizational level reporting structures include i) non-governmental organizational structure, ii) formal healthcare system structures, and iii) government agencies and departments whereas, family and communal structures were the community structures that protect the SRH rights of young people. Some young people lack confidence in these reporting structures and describe them as unnecessary because these structures do not discipline healthcare providers who exhibit unfriendly and undesired attitudes in youth-friendly healthcare centers. At the organizational level, human rights agencies and their roles are featured profoundly. They encouraged the protection of the rights of young people who are accessing SRH services. Government partnership with non-governmental organizations (NGOs), and provision of medical supplies encouraged the utilization of health facilities. Community acceptance and support encouraged program managers to actively engage with young members of the communities. Young people reported financial limitations, lack of awareness of these reporting structures, and their access as challenges to reporting healthcare providers who infringe on their SRH rights.

Conclusion: There is a need for implementers and policymakers to increase awareness, establish new structures, and strengthen existing ones for the protection of SRH rights of young people and better SRH outcomes.

Keywords: Sexual and reproductive health services, young people, structural support system

Background

Sub-Saharan Africa (SSA) has some of the worst indices regarding adolescent and young people's sexual and reproductive health (SRH) [1–4]. With the decreasing age of menarche, sexual debut, in many countries in the sub-region, takes place outside marriage against the background of poor and inaccurate SRH knowledge [5]. By age 20, approximately 77% of young people in the sub-region would have had their first sexual encounter, with very little use of contraceptives [6]. Thus, it is not surprising that SSA has the highest rate of child marriage, and the highest levels of unmet need for contraception among adolescents [2]. While the global adolescent birth rate has decreased from 60 to 43 births per 1000 girls aged 15–19 years, in the past 25 years, the corresponding rate in the sub-region has decreased from 133 to 104 per 1000 girls aged 15–19 years [7].

Nigeria is in dire need of SRH services for its teeming young population (15-25), currently comprising over 15% of the total population, and having a significant percentage of SRH needs still unmet [8,9]. For a population that has about 24.4% of its young persons initiated into one form of sexual activity or the other at 15 years, it is a no-brainer that SRH services must be made readily available[10]. Unfortunately, this has not been the case, since about 27.4% of those aged 15-25 are recorded to have unmet contraceptive needs [10].

The benefits of comprehensive SRH services for young people encompass safe health and sexual health, as well as planned reproduction which accommodates young people's economic, social, and educational expectations and realities [11]. However, many young people face several levels of barriers that hinder access to SRH services, often resulting in several negative SRH outcomes spanning health, education, social relationships, and overall well-being [11]. When young people lack access to comprehensive SRH services, they are at risk of risky sexual behaviors, making them susceptible to unplanned pregnancy, sexually transmitted infections (STIs), utilizing alternative medicines and self-medications, and will be faced with associated devastating health and psychosocial consequences.

Conversations on barriers to SRH services have been ongoing in literature [12,13]. However, for the most part, these conversations have largely centered on barriers that are at levels of the individual (downstream) and facilities (midstream), leaving out those barriers that are structural (upstream). Some studies have argued that health services can be delivered efficiently when there is effective interaction across the three levels as already highlighted [14–16]. As regards SRH services in Nigeria, scholars have reported poor and devastating attitudes of health workers toward young people who come to seek SRHS in terms of information and direct services, which is made worse because of the absence of protective measures in place by the system [17,18]. The implication of this is that many young people are deprived of SRH services and lack a way out.

In response to the numerous barriers facing young people seeking SRH services, interventions have been implemented to build the capacities and skills of healthcare providers to deliver youth-friendly SRHR services to young people in Ebonyi State [19]. However, in this State, several cases of rape, gender violence, sexual violence, and other SRH problems have been recorded [19–22]. Healthcare providers are expected

to exhibit positive behaviors and attitudes to young clients after receiving SRH intervention however, they are observed to digress from their professional behavior when providing SRH services to young people.

More on structural influences, there have been highlights about sociocultural norms and values strongly influencing and exacerbating unmet needs for sexual and reproductive health of young people [18,23–25]. This refers to the stigma and stereotypes used to qualify young people who seek SRH services, and such is common in many Nigerian communities [18,23,25]. This situation describes how young people struggle with accessing and utilizing SRH services both in facilities and communities, with barely any response from the broader structure to address such experiences. Additionally, there are gendered framings around access and utilization of SRH services in Nigeria by young people, which are constructed culturally and elevated to a status of being socially normative [18,23]. In the same vein, a study revealed that healthcare providers struggle with contradictory values and beliefs when providing SRH and rights services to their young clients [26].

Indeed, the constraints exercised by structural influences coming from cultures, community orientations, the absence of system-wide complaint mechanisms, etc., on young people accessing SRH services cannot be overstated. Not addressing these structural influences will affect young people's access to a range of services such as accessing and utilizing modern contraceptives; antenatal, childbirth, and postnatal care; treatment of complications of unsafe abortion; and prevention and treatment of sexually transmitted infections including HIV [11,27]. In contrast, young people's swift and unhindered access to SRH services could improve maternal health services, prevent unintended pregnancies, STIs, and treatment of STIs including HIV/AIDS among this population [27,28].

Efforts are made to increase community and individual access to SRH services [19–21]. However, to ensure unhindered access and utilization of SRH services by young people, there should be enabling and supportive structures within the system that protect the rights of young people to reduce the effects of harmful norms on the delivery of inclusive youth-friendly SRH services. Unfortunately, there is a lack of evidence about these structures and their roles in promoting access to SRH services for young people.

This paper aims to identify these structures that have been put in place to protect the SRH rights of young people and to communicate how helpful these structures can be to a comprehensive intervention that will target the SRH of young people in Nigeria. Our study has in it the potential to close gaps in SRH services that encourage unmet sexual and reproductive health needs of young people. It will provide evidence-based findings that can inform policymakers, planners, and other stakeholders on strengthening the existing structures, thereby promoting supportive environments necessary for the provision of comprehensive and inclusive SRH services.

Methods

Study design and study area

This was a cross-sectional qualitative study undertaken in three urban and three rural Local government areas (LGAs) in Ebonyi state. The State is one of the five southeastern states in Nigeria with an estimated

annual growth rate of 2.7%[29]. Ebonyi State has an estimated total population of 4,339,136 and over 355 thousand are between the age of 15 to 24 years [9,30]. The State has a 5,533 km^2 estimated land area [9].

Sampling

Three urban and three rural LGAs were purposively selected for this study based on their prioritization by the Ebonyi State government for SRH interventions. To ensure adequate geopolitical and geographical (urban/rural) representation, two LGAs were selected from each of the three senatorial zones in Ebonyi State. In each LGA, a community at least one functional public healthcare facility that provides youth-friendly SRH services was selected for this study.

Study population

The study population were young people aged 15-24 years and primary healthcare (PHC) service providers. The PHC service providers were purposively selected from the primary healthcare (PHC) facilities where adolescent SRH intervention has been previously implemented. These service providers have been trained to provide SRH services to adolescents in the community. Young boys and girls regardless of their schooling or marital status are randomly selected from the communities where the selected primary healthcare facilities are situated to participate in the study.

Data collection

The data were collected using focus group discussions (FGDs) and in-depth interview (IDI) guides. These guides were designed by qualitative research experts and pre-tested among the target audiences in a contiguous state. The FGD guide was used to collect data from young people and the IDI guide was used to elicit information from PHC service providers.

A total of twenty IDIs were held with PHC service providers - ten IDIs held with those in urban areas and 10 with those in rural areas. A total of eleven interviews were held with young people aged 15-24 years. The FGDs held with young people were disaggregated by sex (male/ female) and age (15-18 years, and 19-24 years). The FGD sessions had an average of 6-7 participants.

The interviews were conducted by experienced social scientists who were trained to understand the objectives of the study and interview guides. Data was collected for a period of two months. All interviews were facilitated by a moderator and a note-taker. The interviews were audio-recorded with the permission of the participants. All the interviews were conducted in English, and discussions were held in convenient venues for the participants. Participants were informed of the objectives of the study and their roles and rights in the study. Written informed consent was obtained from each participant before the interviews began**.**

Data Analysis

Following each interview session, the audio-recorded discussions were transcribed verbatim and anonymized by the note-takers. Each transcript was read by the interviewer /moderator, and further edited for spelling and punctuation errors.

Thematic analysis of transcripts was performed using a deductive approach. A generic coding framework was first developed based on the objectives of the assessment. The description of the structures - refers

to the organizational structures, government policies, programs, strategies, and plans, and family or community-level structures put in place to protect the sexual and reproductive health and rights of young people and to reduce the effects of harmful social and cultural (including gender) norms on the SRH of young people.

The transcripts were imported into NVivo software and coded. Word query output was generated for each code and read to identify sub-themes presented in this study as shown in figure 1 below.

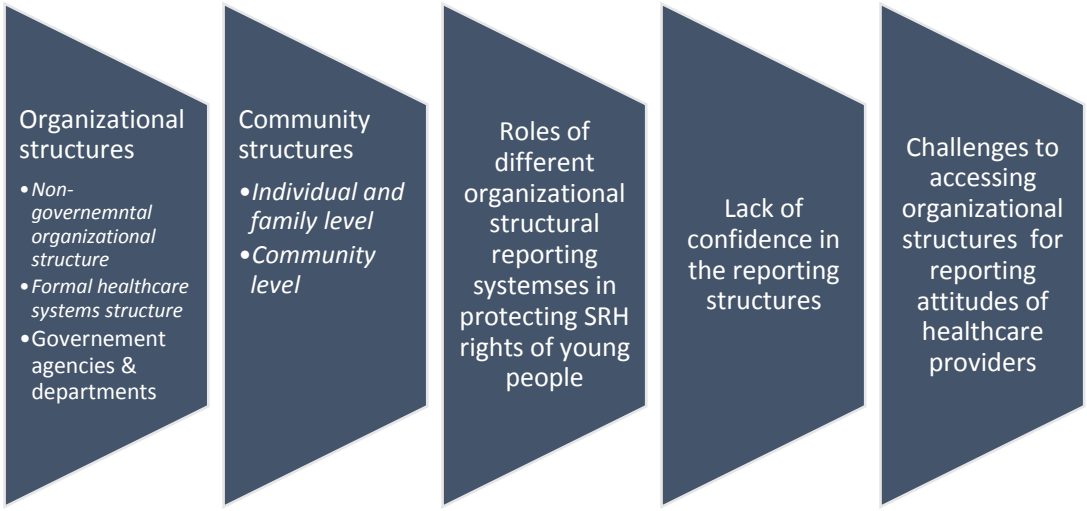

Figure 1: identified themes and sub-themes presented in the findings.

Findings

Our findings showed that there are existing structures where vulnerable young people report healthcare providers who exhibit negative attitudes towards them and their peers when seeking SRH services. These reporting structures help to protect their SRH rights and reduce the effects of harmful socio-cultural and gender norms that influence healthcare providers' attitudes in the delivery of youth-friendly SRH services to young people. The reporting structures are presented in two levels namely, Organizational structures, and Community structures.

Organizational structures

Young people revealed several organizational structures that they report undesired/ unfriendly attitudes of healthcare providers when seeking SRH information and services in primary healthcare facilities. However, to protect the SRH rights of young people, and reduce the effect of harmful norms, young people revealed several organizational structures that they report harsh/ unfriendly attitudes of healthcare providers when seeking SRH information and services. Three different organizational level reporting structures were described by young people and healthcare providers which include i) non-governmental organizational structure, ii) formal healthcare system structures, and iii) government agencies and departments.

a. Non-governmental organizational (NGO) structure

The finding reveals that young people report their negative experiences as regards providers' attitudes to human rights activists and other NGO-established centers for the protection of SRH rights. The presence of active NGOs concerned with human rights, child protection, and gender-based violence is an important structure that helps to ensure the delivery of youth-friendly SRH services for all categories of young people in the State.

Some non-governmental organizations work with health agencies in the state to improve the practice, attitudes, and skills of healthcare providers in the delivery of SRH services. These NGOs established individual and healthcare facility channels for young people to report their challenges as regards violence and providers' attitudes in delivering SRH services. These help to reduce the effects of harmful social and cultural (including gender) norms on the SRH of young people and other community members. Some young people are part of these NGOs reporting networks and they also trust them to protect their rights when they are violated. Below are some quotes to support the finding.

> *In this child protection network, I am one of the technical team members, and they channel their complaints to me. In the child protection network, some adolescents are working in this place, if they see any violence against children and women, they will call me, … Even when the place is not in our jurisdiction, I will call the person in charge of that local government …" (IDI_RUR13 - health provider in a rural facility)*

> *"In this aspect, I think that I will report to the human rights activist or human rights centre so that they will go on an investigation and bring the person to order." (FGD_20 years young boy in an urban community, participant 2)*

b. Formal healthcare systems structures

Many young people described that they report their complaints immediately to health facility managers such as the doctor or nurse in charge of the healthcare facility, the providers' colleague, or the most superior healthcare provider in the facility. Some young people believe that reporting a healthcare provider to the provider's colleague (especially their seniors) should be the first required action. But they are also willing to take the case further to non-governmental organizational structures established and interested in protecting their SRH rights as revealed in the following:

> *"You will report to her superior in the office So, that she will know how to caution her because it is possible that the junior nurse does not know what she was doing." (FGD_15 years young girl in a rural community, participant 4)*

> *" But first of all, I will report the person to the superior worker in the health center and know if something will be done before I will engage human rights activists." (FGD_20 years young boy in an urban community, participant 2)*

> *"If you go to the healthcare facility and they did not attend to you the way you like, because there are some people that have no manner, and there are some people that if you are talking, they will not listen to you, you may get angry that the person did not respect you or that the person is insulting you., You can meet their co-worker. On most occasions, the co-worker will start attending to you. It is after attending to you that the co-worker will meet with that provider and tell her this*

is how you will be treating a patient. So, you can report to co-workers there." (FGD_16 years young boy in a rural community, participant 2)

Few young girls categorically mentioned that when a healthcare provider's attitude becomes unfriendly, their first action will be to boldly confront the healthcare provider. However, if the health provider disregards her opinion due to their age, then they will go ahead to report the health provider to the health facility manager.

> *"… if I don't want to report it to the doctor, I will meet that nurse and talk to her directly that I don't like what she said and she shouldn't repeat it next time. If I confront her and she takes me as a small girl and starts shouting at me or tries chasing me out of the hospital I will meet the doctor in charge of the facility." (FGD_20 years young girl in a rural community, participant 6)*

> *"For me, I will not report to anybody, rather I will talk to the health worker about how to attend to clients. If the person has an ear, he or she will hear." (FGD_17 years young girl in a rural community, participant 5)*

Conflicting to young people's opinion, many healthcare providers believe that they are friendly to young people who seek SRH services in their health facility and there is no need to report them to anyone. Some of them mentioned that they are part of a protection network technical team trained to provide friendly SRH services to young people and protect the community members from any form of violence. Below are some quotes to support the finding.

> *"But people that work with me here, they don't talk anyhow to the young people, they don't react or talk negatively or different from my own attitude towards the client. This is because I always step down the training. Again, in every meeting we do, if I notice any new thing, because we met every month, during the meeting I also refresh their memory on those things. In this child protection network, I am one of the technical team members, and they channel their complaints to me."* – IDI_RUR13 – *a health provider in a rural facility*

> *"As I have said earlier, our reaction is a positive one, though our training as health workers helped us not to react negatively, it improves our attitude towards them. We have been trained on the way to handle those individuals, whether boy or a girl, married or unmarried, educated or not, whether the person is from a poor home or not, rich, or poor, educated or not, whether the person is a school dropout or not, and every other characteristic on how to handle the client, we handle them the same way." IDI_URB03 - a health provider in an urban facility*

c. Governmental agencies and departments

The finding reveals that some young people directly report to the police department, state government, or local government authorities. This depends on the young person's access to individuals who work with the department or agency.

> *"I can report to the government in Ebonyi State may be to the governor if I know him. But if can't report to him, you may report to the local government chairman or even to the police they can help you sometimes. Just that you must pay the policy to open the case before they can follow you to the health center." (FGD_19 years young boy in a rural community, participant 2)*

Community structures

To assess friendly SRH services and protect their rights, young people revealed that they report harsh/ unfriendly attitudes of healthcare providers to family and communal level structures.

a. Individual and family level

In some cases when they report healthcare providers to the facility management and it does not yield effective results due to their socio-demographic factors, they visit the facility with their parents or guardians. See the below quote.

"For me, I will report to my parents. Then I will visit the hospital with my parents, because in some cases if the nurse shouts at you and you decide to confront the health worker, the health worker might not even listen to you because you're still young. But if you confront the health worker with your parents, they will know that it's serious and the person in charge might call the nurse and caution her." (FGD_22 years young girl in an urban community, participant 2

b. Local/ communal structures

Other existing structures were those at the community level including leaders and influencers. However, only healthcare providers described this reporting system at the community level. For illustration*: "So, using this community stakeholders' people can report to them and such issues, we do not hear or experience it again." _IDI_RUR16 – a health provider in a rural facility*

Roles of different structural reporting systems in protecting SRH rights of young people

Table 1: Roles of different structural reporting systems in protecting SRH rights of young people.

Domain	Roles
Organizational	• Providing consistent training and support to healthcare providers. • Partnership with non-governmental organizations (NGOs) • Active involvement of young people and healthcare providers as agents under established reporting networks • Active NGOs and their readiness to act on issues affecting SRH of young people. • Free provision of some SRH services
Community	• Care supporters - Peers and parents' willingness to encourage and protect young people seeking SRH services. • Accommodating program implementers and organizers • Readiness of community leaders to accept SRH information and act on it. • Existing community vanguards for informing about SRH.

Organizational structures - Our data shows that the government partners with some NGOs in their efforts to ensure that SRH services are accessible to young people. This partnership led to the supply of

some SRH services to young people for free in the hope that financial barriers would be cut off. However, the extent of free health service coverage for young people was not sufficiently described.
Our findings showed that routine drugs, x-rays, and family planning services are said to be free in primary healthcare facilities. There is Ebonyi State Health Insurance Agency (EBSHIA), which according to the participants, *"for those of them that are enrolled in EBSHIA, we don't ask them for any money"* (IDI_URB09 – a health provider in an urban facility)

> *"No challenge, I don't have any challenge because Awka people use to supply us with materials, I have enough commodities now. Then MARIE STOPES also gives us consumables, though if there is any agency that will be supporting us with consumables, it will be good. ANC is free, and EBSHIA is supporting us."* (IDI_URB03 – a *health provider in an urban facility)*

Likewise, pregnancy tests are conducted for free without the need for registration: *"For those that want to run a test, maybe the person says that she missed her period, we usually confirm whether it is positive or negative, we don't ask the person to get a card, SRH services are free." (IDI_RUR15 - a health provider in a rural facility).*

Data also revealed that occasionally, healthcare providers are mandated to undergo training to improve their delivery of SRHS. These trainings are designed to help healthcare providers acquire the knowledge and skills to provide SRH services to young people from different backgrounds. Despite the importance of these trainings, they are not regular and are not designed to accommodate all the staff. So, the attending staff which is usually a senior health worker is expected to step down to their colleagues during meetings:

> *"We do step down the training given to us; we teach everything they taught us to those at the facility so that they will know that we also trained all the staff at the facility. No, we use to step down the training to everybody, they don't treat or react to them (young people) differently. I told you that all my colleagues are trained on that perspective, we do step-down the training to every staff, on how to handle a patient." – (IDI_ RUR16 – a health provider in a rural facility)*

Community structures - Our findings showed that community leaders are not only ready to participate in programs to improve the SRH of young people, but they are also willing to implement their recommendations. Town announcers on the other hand work with healthcare providers and NGOs to ensure the dissemination of health information. For illustration:

> "*We have not had such issues here. The government and some non-government organizations have come into the community, called all the village heads and stakeholders of this community, and talked to them about the sexual and reproductive health of young people. So, using these community stakeholders we do not hear of such here." (IDI_RUR16 – a health provider in a rural facility)*

> "*We usually call for health talks, we use town announcer to inform them about general health talks and the community leaders use them (town announcers) to reach out to young people" - (IDI_RUR15 – a health provider in a rural facility)*

Communities are accommodating and promoting the sexual and reproductive health of young people. Besides, they also invest their time to participate in these activities leading to positive health behaviors.

As revealed in the following quote, program officers and implementers may reside in these communities until their program is concluded:

> *"IHP people have done that, they came and stayed for one month, hosting town hall meetings and lecturing people of this community on the importance of family planning in the prevention of unwanted pregnancy. [They said] instead of your daughter getting pregnant and stop schooling or going to do abortion, it's better to do family planning and the community accepted that. Sometimes you will see a mother bringing her daughter for us to do the family planning. I was surprised that day, sometimes the girl came by herself, since last year they created that awareness, we have put implants for more than 10 persons." (IDI_RUR16 – a health provider in a rural facility)*

Young people revealed the support of key persons to access SRH services. Some peer groups and parents featured prominently as strong supporters. Peer groups could serve to provide the initial encouragement to seek maternal care services in PHCs while parents were mentioned as go-to persons to protect young health seekers who were treated negatively by healthcare providers.

Lack of confidence in the reporting structures

Our findings showed that some young people lack confidence/trust in these reporting structures. Although many young people believe that it is necessary to report any unfriendly attitude of healthcare providers, few opined that it is unnecessary to report the providers. They believe that these structures do not discipline healthcare providers who exhibit unfriendly and undesired attitudes in youth-friendly healthcare centers. Young people further described that the negative attitude of health providers may not change except if they desire to change their attitude toward young people who seek SRH services. As a result of lack of trust, young boys, and girls discuss their experiences with peers and avoid utilization of services provided in the healthcare facilities if necessary. Rather, they utilize the healthcare facilities that have healthcare providers who offer friendly SRH services. See some resonating quotes to support the findings.

> *"I will not report it to anybody, rather I will change and go to another health facility because they will not change their attitudes except, they feel like doing so." (FGD_15 years young girl in a rural community, participant 6)*

> *"The highest you can do is to report to your friend. This is for them to know what that person [healthcare provider] is doing so that they will not be a victim." (FGD_18 years young boys in an urban community, participant 5&4)*

> *"Even if you report them to their fellow health workers, they will not do anything, they will just be broadcasting your name and if you carry your girlfriend, they will be announcing that you carry a particular stickiness." (FGD_17 years young boy in an urban community, participant 2)*

Challenges to accessing structures for reporting attitudes of healthcare providers.

Young people reported few challenges to accessing the structures for reporting healthcare providers who infringe on their SRH rights. They mentioned that there is a lack of awareness about some of these reporting structures and where they can be accessed. There is also a lack of reporting channels at the state or local government level to consistently supervise the healthcare facilities, including the facility managers. Young people mentioned financial limitations for those who decides to report healthcare providers to the police department.

"Even the police, they can help you sometimes. Just that you must pay the policy to open the case before they can follow you to the health center." (*FGD_19 years young boy in a rural community, participant 2)*

"Because some people don't even know where these human rights centers are, and they don't even know that they can report this health worker if they do what they do not like." (FGD_22 years young boy in an urban community, participant 6)

Discussion

Using a qualitative research method, this study took a first step to explore existing structures for reporting unprofessional attitudes of healthcare providers in the delivery of youth-friendly SRH services. Findings revealed that when seeking SRH information and services, young people report unprofessional /negative attitudes of healthcare providers to different existing organizational and community structures that protect their SRH rights. These structures also help to reduce the effects of harmful social and cultural (including gender) norms on the provision of SRH services to young people. Akazili and colleagues argued in their study that existing structures can be leveraged to improve SRH outcomes for young people [31].

The lack of awareness about structures that protect sexual and reproductive health rights and their accessibility among young people in this study is a significant concern. Interventions have been implemented in the study state to ensure that young people have access to services and resources to make informed decisions about their SRH [19–21]. Although these interventions have been ongoing, the lack of awareness of existing structures that protect SRH rights has serious implications on health, access to services, welfare, economic development, and poverty reduction of young people [32]. According to a knowledge brief by the World Bank Group, inadequate access to health information and services contributes to a lack of knowledge and awareness about sexuality, and basic human rights [32]. It is essential to address these challenges by raising awareness about existing reporting structures for unprofessional attitudes of healthcare providers among young people. This will foster an environment that respects the SRH rights of young people and empower young people with the knowledge and resources they need to make informed decisions about their SRH rights.

The findings showed that organizations promoting rights to young people are facilitating access to SRHS. They also help to address the effects of harmful norms on the SRH of young people and other community members. In this study, some young people trust that human rights organizations will come to their aid if they report to them. This could be due to the strategy of engaging and including some young people as advocates of SRH issues. However, there are young people in this study who lack confidence in these existing reporting structures. Corroborating with this finding, a study has reported the lack of trust of young people in institutions and organizations [33].

In this study, non-governmental organizations partner with the government to provide periodic training for some healthcare providers. Government has an important role to play in improving access to SRHS. Besides providing and equipping health facilities, they also need to ensure that the capacities of health workers are improved to meet the demand for SRHS. In a study conducted in Plateau State, 90% of health workers reported that they had never had formal training on adolescent SRH [34]. In this study, those who attended the training were asked to step down the training to those healthcare providers in the facility who were not invited. As recommended by a South African study, it is important that more than one member of the facility staff in youth-friendly health centers should be trained to allow for staff turnover [13]. Educating and training healthcare providers is a responsive strategy for ensuring that young people's access to SRHS is protected. Efforts must be made to widen the number of participants and reduce the challenges of stepping down key learnings.

The community acceptance and support clearly as demonstrated in this study mean that implementers and program managers are given access to the community and are provided with the resources to achieve their objectives. The success of SRH programs and interventions rests on community acceptance and support. It is acknowledged by previous studies that communities know their health needs and their involvement is key to program sustainability [35,36]. Therefore, this calls for robust engagement and the establishment of more formal reporting structures in communities to ensure that the SRH rights to services among young people and other community members are not breached.

Young people in this study could trust their parents to protect their SRH rights when they feel that it has been violated by healthcare providers. This implies that parents and guardians play significant roles as care supporters, essential advocates, and partners in addressing the unprofessional attitudes of healthcare providers. Within the community structure, parents and peers were identified as having crucial roles to play in promoting access to friendly SRH services provided in healthcare facilities. This differs from other studies which reported that young people discourage their peers from accessing services in facilities due to the fear of being poorly treated [37]. Another study showed that young people are not ready to discuss their SRH issues with their parents because they perceive them as unsupportive of their romantic relationship [38].

The use of a qualitative research approach in this study limits the generalization of the findings, and there could be social desirability and information bias due to the sensitive nature of the topic. However, triangulation using both IDI and FGD data and engaging two different population groups helped researchers gain a holistic understanding of structures that have been put in place to protect the SRH and the rights of young people. Information on established mechanisms or guiding principles for addressing and protecting the SRH rights of young people in these structures was not explored. These study findings were validated by the participants during a two-day evidence synthesis workshop.

Conclusion

This study provided insight into the structures that have been put in place to protect the SRH rights of young people who experience negative attitudes from healthcare providers while seeking youth-friendly services. Findings showed that there are existing organizational and community reporting structures that help to reduce the effects of harmful social and cultural (including gender) norms on the SRH of young people. Although many young people believe that it is necessary to report the unprofessional attitudes of healthcare providers, few opined that it is unnecessary to report them because they will not be disciplined by these structures. Young people reported financial limitations, lack of awareness of these reporting structures, and how to access them as challenges to reporting healthcare providers who infringe on their SRH rights.

The study identified openings for implementers and policymakers to establish or strengthen structures that will protect the SRH rights of young people. This will help to improve the SRH outcomes of young people. Communities have proven to be a strong base for promoting SRH messages. Proper engagement with key actors will encourage their continuous support for SRH issues. It would be useful for researchers and program managers to consult existing community and organizational structures that specialize in protecting the SRH rights of young people in youth-friendly facilities. An in-depth exploration will enable an understanding of their established mechanisms or specific guidelines.

Ethical approval

The project proposal was submitted to the Research and Ethics Committee of Ebonyi State Ministry of Health and, the Health Research Ethics Committee of University of Nigeria Teaching Hospital Enugu. Ethical approval was secured from both committees before the study commenced. Written informed consent was obtained from all the healthcare workers who participated in the study. For young people aged 15 to 17 years, informed written consent was obtained from parents/ guardians. Also, written assent was obtained from those aged 15 to 17 years, and older people between the ages of 18 to 24 years consented for themselves.

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